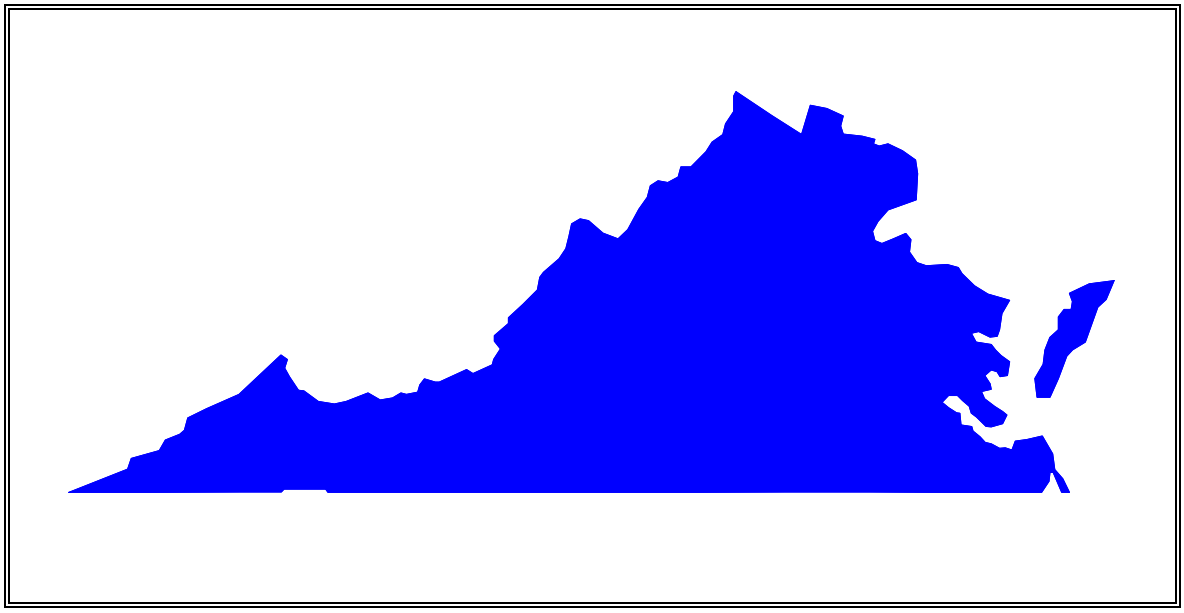
Virginia Department of Medical Assistance Services

Companion Guide

For 835 Health Care Claim Payment Advice

***Document Version 1.6 Updated* 04/01/2008**



ASC X12N 835
VERSION 004010 X091A1

First Health Services Corporation
4300 Cox Road
Glen Allen, VA 23060

VERSION CHANGE SUMMARY

VERSION NO.	DESCRIPTION	DATE
Version 1.0 -	Original Implementation	12/05/2002
Version 1.1 -	Updated paper RA reference in *PURPOSE* "A (full) paper RA will be provided for the first **30** days of operation…" - page 3	11/17/2003
Version 1.2 -	Added Page reference 49 Segment BPR – BPR11 data element Added Page reference 53 Segment TRN – TRN04 data element	08/01/2004
Version 1.3 -	Changes for NPI	12/01/06
	Added NPI Notes - page 4	
	Added Page reference 73	
	Segment N1 - N103 & N104 data element	
	Segment REF – REF02 data element	
	Modified Page reference 79	
	Added program code 09 – Medicaid Expansion	
	Modified Page reference 81	
	Segments TS3 – TS301 data element	
	Modified Page reference 113	
	Segment NM1 – NM108 & NM109 data elements	
	Correct references to Pages 154 & 155	
	Added Page reference 126 & 127	
	Segment REF – Servicing ID	
	Modified Page reference 170	
	Segment PLB – PLB01 data element	
Version 1.4	Modified Special Notes 2, 3, 4 & 5	06/06/2007
	NPI Contingency Dual Use Period	
	Modified comments for Page reference 78 – REF01 & REF02	
	Modified comments for Page reference 81 – TS031	
	Modified comments for Page reference 113 – NM109	
	Modified comments for Page reference 170 – PLB01	
Version 1.5	Modified comments for Page reference 79 – LX01	06/29/2007
Version 1.6		04/01/2008
	Modified Special Notes – deleted note 2; modified notes 1, 3, 4 & 5 ; renumbered notes	
	Removed blue highlighting from previous changes	

Modified comments for NPI and API usage (page reference 78 Loop 1000B REF02)
(page reference 81 Loop 2000 TS301)
(page reference 113 Loop 2100 NM109)
(page reference 127 Loop 2100 REF02)
(page reference 126 Loop 2100 REF01 and REF02 deleted 1D)
(page reference 170 PLB01)

INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires that Medicaid, and all other health insurance payers in the United States, comply with the EDI standards for health care as established by the Secretary of Health and Human Services. The ANSI X12N implementation guides have been established as the standards of compliance for claim transactions.

First Health Services Corporation (FHSC) is the fiscal agent for the Department of Medical Assistance Services (DMAS). First Health is providing the following information to serve only as a companion document to the HIPAA ANSI X12N implementation guides. The use of this document is solely for the purpose of clarification. The information describes specific requirements to be used for processing data. This companion document supplements, but does not contradict any requirements in the X12N implementation guide. Additional companion documents/trading partner agreements will be developed for use with other HIPAA standards, as they become available.

Additional information on the Final Rule for Standards for Electronic Transactions can be found at http://aspe.hhs.gov/admnsimp/final/txfin00.htm. The HIPAA Implementation Guides can be accessed at http://www.wpc-edi.com/hipaa/HIPAA_40.asp.

PURPOSE

The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication and/or claim predetermination for benefits. It is used to send an Explanation of Benefits (EOB) remittance advice in the VAMMIS System.

An 835 is used by DMAS to convey an Explanation of Benefits (EOB) information which explains what is or is not being paid on the claim that has been submitted, and why to the provider. DMAS will make a payment with an electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's account receivables using the 835.

When payment is due, multiple 835 transactions may be used to fulfill the obligation. In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the

notification of pending claims. The 276/277 Claims Inquiry/Response transaction set will be used by FHSC to respond to customers requesting status on pending claims.

The 835 is designed so the electronic remittance can automatically be posted to a provider's accounts receivable. Standard HIPAA Claims Adjustment Codes and Remarks Codes will replace DMAS Edit and EOB codes on the 835 transaction but both will appear on the paper remittance (RA). The paper RA will continue to include pended claims but will not be included on the 835 transaction. A (full) paper RA will be provided for the first 30 days of operation to assist providers in determining that the 835 matches the paper RA. The 'RA Message' will be retained on the paper RA. A cross reference of the DMAS Edit and EOB codes to the Standard HIPAA Claims Adjustment Codes and Remarks Codes is available on the DMAS Web Page.

An 835 is initiated by DMAS and may be sent as follows:

- DMAS to provider
- DMAS to a service center to provider
- DMAS to value added network (VAN) to provider
- DMAS to billing service to provider
- DMAS to independent practice association to provider

The basic business flow of the 835 is from the payer to the health care provider that provided the health care service. Both the DMAS and the provider may contract with other parties for the performance of various administrative services. VANs/clearinghouses may perform either value added services or simply a service as a communications pipeline.

SPECIAL NOTES

1. Financial Adjustment Reason Codes - A composite reference identifier in the PLB03-02 (PLB05-02 and etc) segments describe a provider level Financial Adjustment Transaction. A component of this identifier is referred to as the DMAS Financial Adjustment Reason Codes. These reason codes and their descriptions are available on the DMAS Web Page.

2. As of 05/23/08 only the NPI or Atypical Provider Identifier (API) will be used to adjudicate claims. All claims received on or after that date will be processed using the NPI or API. **The compliance date is based on the date of receipt and not the date of service**.

3. If the NPI was used to adjudicate the claim then it will be returned on the 835 as the Primary Identifier in N104 (Loop 1000B). The Tax ID will be moved to the secondary REF segment in Loop 1000B. The Tax ID will continue to be returned after the end of the NPI Contingency Dual Use Period.

4. Non-healthcare providers that are not eligible to obtain an NPI will receive a new 10-digit Virginia Medicaid Atypical Provider ID (API) assigned by DMAS. The API will be returned on

the 835 in the REF segment in Loop 1000B with qualifier 1D. The Tax ID will remain in its current location as the Primary Identifier (N104 Loop 1000B).

Data Element Descriptions

Page	Loop	Segment	Data Element	Comments
197	N/A	ISA	ISA01 - Authorization Information Qualifier	00 - No authorization information present
198	N/A	ISA	ISA03 - Security Information Qualifier	00 - No security information present
198	N/A	ISA	ISA05 - Interchange ID Qualifier	ZZ - mutually defined
198	N/A	ISA	ISA06 - Interchange Sender ID	VMAP FHSC FA
198	N/A	ISA	ISA07 – Interchange ID Qualifier	ZZ - mutually defined
199	N/A	ISA	ISA08 - Interchange Receiver ID	Medicaid Service Center
199	N/A	ISA	Interchange Control Version Number	00401 - Version Number
200	N/A	ISA	ISA14 - Acknowledgment Requested	0 – No acknowledgment requested
200	N/A	ISA	ISA15 - Usage Indicator	P - Production or T - Test
200	N/A	ISA	ISA16 - Component Element Separator	'>'
202	N/A	GS	GS02 - Application Sender's Code	Use 'VMAP FHSC FA'
202	N/A	GS	GS03 - Application Receiver's Code	4 digit Service Center ID assigned by Virginia Medicaid
203	N/A	GS	GS08 - Version/Release/Industry Identifier Code	004010X091A1
45	N/A	BPR	BPR01 - Transaction Handling Code	I - Remittance info only or H - Information Only if BPR02 = 0
46	N/A	BPR	BPR04 - Payment Method Code	ACH - Automated Clearing House if EFT is used, CHK if paper check, NON if no funds are transmitted; If BPR04 = CHK or NON then BPR05 through BPR12 are blank.
49	N/A	BPR	BPR10 - Originating Company Identifier	546116277 DMAS Fed Tax ID
49	N/A	BPR	BPR10 – Originating Company Supplemental Code	If BPR04 = ACH, then this is the RA Advice Number
52	N/A	TRN	TRN01 - Trace Type Code	1 - Current Transaction Trace Number
53	N/A	TRN	TRN02 - Reference Identification	Check or EFT trace number
53	N/A	TRN	TRN03 - Originating Company Identifier	1 plus Fed Tax ID - 546116277 DMAS Fed Tax ID
53	N/A	TRN	TRN04 - Reference ID	RA Advice Number

Page	Loop	Segment	Data Element	Comments
57	N/A	REF	REF01 - Reference ID Qualifier	EV - Receiver Id
57	N/A	REF	REF02 - Reference ID	Medicaid Service Center
60	N/A	DTM	DTM01 - Date/Time Qualifier	405 - Production
61	N/A	DTM	DTM02 - Date	Weekly End Date
62	1000A	N1	N101 - Entity Identifier Code	PR - Payer
63	1000A	N1	N102 - Name	DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
64	1000A	N3	N301 - Address Information	P.O. Box 26228
65	1000A	N4	N401 - City Name	GLEN ALLEN
65	1000A	N4	N402 - State or Province Code	VA
65	1000A	N4	N403 - Postal Code	232606228
70	1000A	PER	PER01 - Contact Function Code	IC - Information Contact
70	1000A	PER	PER02 - Name	Provider Help Line
70	1000A	PER	PER04 - Communication Number	Telephone Number - 8005528627
73	1000B	N1	N103	XX – NPI FI – Federal Tax ID or SSN
73	1000B	N1	N104	NPI or Federal Tax ID depending on qualifier sent in N103.
78	1000B	REF	REF01	TJ – Federal Tax ID 1D – Medicaid Provider Number
78	1000B	REF	REF02	The Federal Tax ID will be returned in this segment if the NPI is returned in 1000B N104. As of 05/23/08, only the API will be returned with qualifier 1D.
79	2000	LX	LX01 - Assigned Number	Unique number starting with ‘1’ and incremented by ‘1’

Page	Loop	Segment	Data Element	Comments
81	2000	TS3	TS301 - Reference Identification	Servicing Provider Id As of 05/23/08, only the NPI or API will be returned.
81	2000	TS3	TS302 - Facility Code Value	If Claim Types = 1 (UB92 Hospital Inpatient), 2 (UB92 SNF), 3 (UB92 Hospital Outpatient/Home Health), 10 (UB92 ICF) uses **Bill Type**; If Claim Types = 4 (HCFA Personal Care), 5 (HFCA Practitioner), 8 (HFCA Lab), 14, 15 (Capitation Payment), uses **Place of Service**; If Claim Types = 06 (Drug), 09 (Title 18), 11 (Dental), 13 (HFCA Transportation), 16 (Management Fees), 17 (Administrative Fees), 96 (Assessments) which have no Place of Service, **defaults to 99**.
89	2100	CLP	CLP01 - Claim Submitter's Identifier	Claim Patient Account or RX Number returned from 837 CLM01. If no Patient Account Number or RX number then field defaults to 0
92	2100	CLP	CLP06 - Claim Filing Indicator Code	Type of claim: MC = Medicaid, Assessments, and Medicaid Expansion; LM (Liability Medical) = TDO, SLH, HIV Premium Pay, Regular Assisted Living, and HIDP; OF (Other Federal Program) = FAMIS. The default is LM.
93	2100	CLP	CLP07 - Reference Identification	ICN CCYYDDD ICN media code ICN batch sequence ICN line no
93	2100	CLP	CLP08 - Facility Code Value	Bill type or Place of Service returned from 837 CLM05-1
93	2100	CLP	CLP09 - Claim Frequency Type Code	Claim frequency Note- returned from 837 CLM05-2 on the Institutional claims only

Page	Loop	Segment	Data Element	Comments
97	2100	CAS	CAS - Adjustment Reason Codes	If multiple errors found with a claim or additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
102	2100	NM1	NM101 - Entity Identifier Code	QC – Patient
103	2100	NM1	NM108 - Identification Code Qualifier	MR = Medicaid Recipient ID, including Assessments MI (Member ID) = TDO, SLH, HIV Premium Pay, Regular Assisted Living, HIDP, FAMIS MI is the default.
112	2100	NM1	MN101 - Entity Identifier Code	82 -Rendering Provider
113	2100	NM1	NM108 - Identification Code Qualifier	XX - NPI or MC – Medicaid
113	2100	NM1	NM109 - Identification Code	Servicing Provider ID As of 05/23/08, only the NPI or API will be returned.
122	2100	MIA	MIA20 – MIA24 - Reference Identification – Remark codes	If multiple errors found with a claim or additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
124	2100	MOA	MOA03 – MOA09 - Reference Identification – Remark codes	If multiple errors found with a claim or additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
126	2100	REF	REF01 - Reference ID Qualifier	G1 - Prior Authorization Number
127	2100	REF	REF02 - Reference ID	Prior Authorization Number and PA line number

Page	Loop	Segment	Data Element	Comments
140		SVC	SVC - Service Line	The service line loop will occur once for professional claims. For UB claims invoice 03 HH/outpatient this loop may occur once for each revenue line
140	2110	SVC	SVC01 – SVC03 - Procedure Modifier	As many as four Claim procedure modifiers will be reported
150		CAS	CAS - Claim Adjustment	This segment will appear at the line level for Outpatient/Home Health claims only. If multiple errors found with a claim line or additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
154	2110	REF	REF01 - Reference Identification Qualifier	6R - Provider Control number
155	2110	REF	REF02 - Reference Identification	Line item control from 837
162	2110	LQ	LQ02 - Industry Code - Remark code	If multiple errors found with a claim or additional benefit explanations are needed, only the first Adjustment Reason Code encountered will be used in the CAS segment. The remaining error or benefit explanation codes will be reported in the Remarks Codes.
170	N/A	PLB	PLB01 – Billing Provider ID	As of 05/23/08, only the NPI or API will be returned.
170	N/A	PLB	PLB03-02 - Reference Identification	A composite of : benefit program code + financial control number + DMAS financial Adjustment Reason Code + balance forward indicator